Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

Amended Public Copy/Copie modifiée du public

Report Date(s)/ Date(s) du Rapport	Inspection No/ No de l'inspection	Log #/ No de registre	Type of Inspection / Genre d'inspection
Jan 28, 2019	2018_727695_0015 (A1)	027151-18	Resident Quality Inspection

Licensee/Titulaire de permis

Fairview Mennonite Homes
515 Langs Drive CAMBRIDGE ON N3H 5E4

Long-Term Care Home/Foyer de soins de longue durée

Fairview Mennonite Home
515 Langs Drive CAMBRIDGE ON N3H 5E4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by FARAH_ KHAN (695) - (A1)

Amended Inspection Summary/Résumé de l'inspection modifié

Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

The compliance order (CO) due date for CO #002 has been extended to May 31, 2019.

Issued on this 28th day of January, 2019 (A1)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Inspection Report under *the Long-Term Care Homes Act, 2007*

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Central West Service Area Office
500 Weber Street North
WATERLOO ON N2L 4E9
Telephone: (888) 432-7901
Facsimile: (519) 885-9454

Bureau régional de services du Centre-Ouest
500 rue Weber Nord
WATERLOO ON N2L 4E9
Téléphone: (888) 432-7901
Télécopieur: (519) 885-9454

Amended Public Copy/Copie modifiée du public

Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Jan 28, 2019	2018_727695_0015 (A1)	027151-18	Resident Quality Inspection

Licensee/Titulaire de permis

Fairview Mennonite Homes
515 Langs Drive CAMBRIDGE ON N3H 5E4

Long-Term Care Home/Foyer de soins de longue durée

Fairview Mennonite Home
515 Langs Drive CAMBRIDGE ON N3H 5E4

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

Amended by FARAH_ KHAN (695) - (A1)

Amended Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Resident Quality Inspection.

This inspection was conducted on the following date(s): October 10, 11, 12, 15, 16, 17, 18, 19, 22, 23, 24, 26, 29, 30, 31, and November 1, 2, 5, and 6, 2018.

During the course of the inspection, the following Critical Incident intakes were

inspected:

Log# 006480-17, related to a fall with possible injury

Log# 024390-17, related to a fall with injury

Log# 027858-17, related to resident to resident altercation

Log# 029040-17, related to resident to resident altercation

Log# 029404-17, related to resident to resident altercation

Log# 016790-18, related to a fall with injury

Log# 017632-18, related to resident to resident sexual abuse

Log# 020166-18, related to resident to resident altercation

During the course of the inspection, the following complaints were inspected:

Log# 006153-17, related to continence care and bedtime concerns

Log# 005043-18, related to a written complaint submitted to the home

During the course of the inspection, the following follow-up to Compliance Orders was conducted:

Log# 002437-18, related to falls prevention and management of residents Compliance Order #001 issued under Inspection # 2017_678680_0019

During the course of the inspection the inspectors toured the home, observed

the provision of care and services, reviewed relevant documents including: clinical records, policies and procedures, annual evaluation, training records, and meeting minutes, and observed infection prevention and control practices.

During the course of the inspection, the inspector(s) spoke with residents, family members, personal support workers (PSW), housekeepers, maintenance worker, dietary aides, registered practical nurses (RPN), registered nurses (RN), Behavioural Support Ontario (BSO) team lead, Resident Clinical Coordinators (RCCs), Long-Term Care (LTC) Manager, volunteers, Acting Resident Assessment Instrument - Minimum Data Set (RAI MDS) Lead, the Director of Care (DOC), the Executive Director (ED), and the ED for Parkwood long-term care home.

The following Inspection Protocols were used during this inspection:

Accommodation Services - Housekeeping
Accommodation Services - Maintenance
Continence Care and Bowel Management
Dignity, Choice and Privacy
Dining Observation
Falls Prevention
Family Council
Hospitalization and Change in Condition
Infection Prevention and Control
Medication
Minimizing of Restraining
Nutrition and Hydration
Pain
Personal Support Services
Prevention of Abuse, Neglect and Retaliation
Reporting and Complaints
Residents' Council
Responsive Behaviours
Safe and Secure Home
Skin and Wound Care

During the course of the original inspection, Non-Compliances were issued.

27 WN(s)
14 VPC(s)
7 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD.) Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 19. Duty to protect

Specifically failed to comply with the following:

s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that the residents were protected from abuse by anyone.

a) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, (a) the use of physical force by anyone other than a resident that caused physical injury or pain.

In stage one of the Resident Quality Inspection (RQI), resident #003 informed the Long-term Care Homes (LTCH) Inspector that they experienced altered skin integrity after PSW #117 treated them roughly during care.

Resident #003 stated that they told registered staff about what happened and that the same PSW had been rough with them in the past.

A record review was conducted and on a specific date in 2018, Registered Practical Nurse (RPN) #110 documented that resident #003 showed them an area of altered skin integrity and indicated that it was caused by a staff member during care.

Registered Practical Nurse (RPN) #110, acknowledged that the resident informed them they were abused by a PSW and that they informed RN #122.

The Director of Care (DOC) acknowledged that this incident was alleged abuse.

b) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means, (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Resident #022 had severe cognitive impairment.

A Critical Incident (CI) report was submitted to the Ministry of Health and Long Term Care (MOHLTC) which stated that resident #022 was allegedly sexually abused by resident #014.

A record review revealed that on a specific date in 2018, a staff member saw resident #014 exhibiting sexual behaviours towards resident #022.

After the incident, resident #022 told a staff member that they did not welcome those sexual behaviours.

Personal Support Worker #108 stated that the incident was non-consensual as resident #022 asked resident #014 to stop.

Registered Nurse (RN) #119 acknowledged that resident #022 was sexually abused by resident #014 as it was non-consensual in nature.

The licensee failed to ensure that residents #003 and #022, were protected from abuse by anyone. [s. 19. (1)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #2: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 101. Conditions of licence

Specifically failed to comply with the following:

s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Findings/Faits saillants :

1. The licensee failed to comply with the conditions to which the licensee was subject.

The Long-Term Care Home Service Accountability Agreement (LSSA) with the Waterloo Wellington Local Health Integration Network (LHIN) under the Local Health Systems Integration Act, 2006, in effect from April 1, 2016 to March 31,

2019, required the licensee to comply with the applicable reporting standards and requirements in both Chapter 9 of the Ontario Healthcare Reporting standards and the RAI MDS (Resident Assessment Instrument - Minimum Data Set) Tools. The LSSA agreement also directed the Health Service Provider (licensee) to ensure that the RAI MDS Tools were used correctly to produce an accurate assessment of the residents (RAI MDS data).

During Stage 1 of the Resident Quality Inspection (RQI) process, the LTCH Inspector noted there were several residents that fell within the assigned resident list that had been coded in the RAI MDS data as J5c=1, meaning end-stage disease with six months or less to live.

The LTCH Inspector reviewed a report indicating that 24 out of the total resident bed count of 84 were at end-stage disease with six months or less to live.

The following sample of residents coded in the RAI MDS assessment as J5c=1 were reviewed:

1) Resident #019 was observed to be mobile and accepted afternoon snack from staff.

Their clinical record was reviewed by the LTCH Inspector which identified the resident was actively involved in a restorative program for mobility and was encouraged to participate in activities four to five times per week. They did not have a diagnosis of palliative care or end-stage disease.

The RAI MDS assessment in 2018, coded the resident as end-stage disease, six months or less to live.

2) Resident #020 was observed by LTCH Inspector #695, lying in their bed wide awake and was able to answer questions appropriately.

The clinical record identified the resident was actively involved in a restorative program for mobility, they were encouraged to use their mobility device properly, and they were encouraged to attend group activities and take an active social role within the home. They did not have a diagnosis of palliative care or end-stage disease.

The RAI MDS assessment in 2018, coded the resident as end-stage disease, six

months or less to live.

3) Resident #008 was observed by LTCH Inspector #696 to be sitting and was able to manoeuvre their mobility device without any difficulty. They were able to answer all questions appropriately regarding their medical conditions.

During a review of the resident's clinical record, the LTCH Inspector identified the resident was independent with mobility, they actively participated in physiotherapy to improve their performance in activities of daily living (ADLs), they were assigned to a high functioning activities group and enjoyed the outings and special events. They did not have a diagnosis of palliative care or end-stage disease.

RAI MDS assessment dated in 2018, coded the resident as end-stage disease, six months or less to live.

The acting RAI-MDS lead told the LTCH Inspector that if the resident's Changes in Health, End-Stage Disease and Signs and Symptoms (CHESS) score was higher than three and Personal Severity Index (PSI) score was higher than eight and the resident's ADLs were total care then they coded J5c=1, end-stage disease, less than six months or less to live.

The "Guide to the RAI-MDS 2.0 Assessment Form", in Chapter 2, defines J5c as "End-stage disease; 6 months or less to live – In one's best clinical judgement, the resident with any end-stage disease had only six or fewer months to live. This judgement was to be substantiated by a well-documented disease diagnosis and deteriorating clinical course.

The LTCH Inspector reviewed residents #019, #020 and #008 with the Acting RAI MDS Lead. They told the LTCH Inspector that when coding for J5c=1, they do not review any clinical records, physician notes or identify if there was any clinical deterioration. They based the coding on the CHESS and PSI scores alone.

The Acting RAI MDS Lead acknowledged that the three residents above, were coded as J5c=1 incorrectly. They stated that the home did not currently have any residents that were end-stage disease, six months or less to live based on the RAI MDS definition found in their RAI MDS manual.

4) Resident #005 was observed sitting in a common area on two occasions in

2018. Their most recent RAI-MDS assessment coded them as bedfast. The RAI-MDS manual defined bedfast as 22 or more hours in a bed or recliner. However, there was no indication in the written plan of care that the resident was bedfast.

Registered nurse #103 stated the resident was not considered to be bedfast.

The Acting RAI-MDS Lead indicated that residents are coded as bedfast if they were in their bed or tilt wheelchair most of the time. When questioned about this, the Acting RAI-MDS Lead acknowledged the resident was not bedfast and the coding was incorrect. [s. 101. (4)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

(A1)
The following order(s) have been amended: CO# 002

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 51. Continence care and bowel management

Specifically failed to comply with the following:

s. 51. (1) The continence care and bowel management program must, at a minimum, provide for the following:
5. Annual evaluation of residents' satisfaction with the range of continence care products in consultation with residents, substitute decision-makers and direct care staff, with the evaluation being taken into account by the licensee when making purchasing decisions, including when vendor contracts are negotiated or renegotiated. O. Reg. 79/10, s. 51 (1).

s. 51. (2) Every licensee of a long-term care home shall ensure that,
(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented; O. Reg. 79/10, s. 51 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the annual evaluation of resident's satisfaction with the range of continence care products including consultation with residents, substitute decision-makers (SDM) and direct care staff, was taken into account when making purchasing decisions, including when vendor contracts were negotiated or renegotiated.

The LTCH Inspector reviewed the home's annual continence care product survey sent out in 2017. The survey was sent to residents and family and the results were evaluated in January 2018.

The Long-term Care (LTC) Program Manager acknowledged that direct care staff were not consulted on the range of continence products used in the home. [s. 51. (1) 5.]

2. The licensee failed to ensure that every resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

a) Resident #002 had multiple medical conditions.

During an interview with PSW #106, they told the LTCH Inspector that there was

no written plan for toileting resident #002. The written plan of care did not include an individualized plan for continence care.

Registered Practical Nurse #111 stated that a voiding diary was to be completed upon admission and with a change of status which would identify the resident's individual patterns. The RPN was not sure if this had been completed for resident #002.

The clinical record for resident #002 included a partially completed voiding diary.

During an interview with RCC #124, the lead for the Continence Care and Bowel Management program, they acknowledged the voiding diary for resident #002 was incomplete and the resident did not have an individualized toileting plan to manage their continence.

b) The LTCH Inspector reviewed resident #009's clinical record which assessed the resident on a specific date in 2018, to be incontinent of bladder.

Resident #009 had multiple medical diagnosis.

During an interview with PSW #123, they told the LTCH Inspector that there was no specific schedule for resident #009's toileting needs.

Registered Practical Nurse #111 acknowledged there was no individualized toileting plan for this residents continence care needs.

The RPN stated that a voiding diary was to be completed upon admission and with a change of status which would identify the resident's individual patterns. The RPN was not sure if this had been completed.

The clinical record for resident #009 included a partially completed voiding diary. The plan of care did not include an individualized plan for continence care.

During an interview with RCC #124, the Continence Care and Bowel Management Lead, they acknowledged the voiding diary for resident #009, was incomplete and the resident did not have an individualized toileting plan to manage their continence.

c) Resident #001 had a quarterly MDS assessment completed on a specific date

in 2018, and the residents' continence level was assessed. The plan of care did not include an individualized plan for continence care.

Personal Support Worker #131 informed the LTCH Inspector that they tried a toileting schedule for resident #001 and it was effective some of the time but that the resident continued to have incontinent episodes.

Registered Practical Nurse #111 acknowledged that a voiding diary was not completed for resident #001 and that it should have been in order to create an individualized plan of care to promote continence for the resident.

The licensee failed to ensure that residents #001, #002 and #009, who were incontinent had individualized plans, as part of their plans of care, to promote and manage bowel and bladder continence based on the assessment and that the plans were implemented. [s. 51. (2) (b)]

Additional Required Actions:

CO # - 003 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #4: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where the Act or the Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system (a) was in compliance with and was implemented in accordance with applicable requirements under the Act.

In accordance with Regulation, s.52 (2), when a resident's pain was not relieved by initial interventions, the resident was assessed using a clinically appropriate assessment instrument specifically designed for this purpose.

A complaint was submitted to the MOHLTC stating that on a specific date, resident #008 had a fall which resulted in significant injury. After the fall, the resident constantly complained of pain to a specific area on their body.

The clinical records for resident #008 were reviewed and indicated that on three different dates, the resident complained of pain to a specific body part. Pain interventions were implemented by registered staff however, it was documented that the initial interventions were ineffective.

There was no assessment or any other documentation to identify that resident #008 was assessed using a clinically appropriate assessment instrument after each incident.

Registered Practical Nurse #111 and RPN #105 indicated that it was not the home's practice to use a clinically appropriate assessment instrument when a resident's pain was not relieved by initial interventions.

Registered Practical Nurse #111 acknowledged that on three separate dates, resident #008's pain was not relieved by initial interventions and there was no clinically appropriate assessment instrument completed to assess the resident.

The home's policy "Pain Management", was reviewed and there was no direction for staff to assess the resident using a clinically appropriate assessment instrument when a resident's pain was not relieved by initial interventions.

The DOC acknowledged the home's pain policy did not direct staff to complete

the pain assessment tool when a resident's pain was not relieved by initial interventions.

The home failed to ensure that where the Act or the Regulation required the licensee to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, it was in compliance with and was implemented in accordance with applicable requirements under the Act. [s. 8. (1) (a),s. 8. (1) (b)]

2. Where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was (b) complied with.

In accordance with Regulation, s.48, required the licensee to ensure that the interdisciplinary programs including falls prevention and management, were developed and implemented in the home and each program must meet the requirements as set out in section 30. Each program must have a written description of the program that included its goals and objectives and relevant policies, procedures and protocols to meet the requirements as set out in section 30. O. Reg. 79/10, s.48

a) As a result of an inspection related to a Critical Incident (CI) for a fall that occurred on a specific date in 2017, the LTCH Inspector inspected the two falls that occurred the day prior to the fall in the CI report for resident #017.

The home's policy "Falls Prevention", directed staff to initiate a head injury routine (HIR) and assess the resident's level of consciousness and any potential injury associated with the fall.

During an interview with RN #125, they stated at the time of the incident, it was the expectation of the home as per their policy, that the head injury routine be implemented.

The LTCH Inspector reviewed the clinical record and noted that the HIR did not have all the required documentation.

The HIR documentations were reviewed with RN #125 who acknowledged that they were incomplete and not in accordance with the home's policy at the time and the expectation of the home regarding the management of head injury

assessments.

b) On a specific date in 2018, resident #022 fell twice and a HIR was initiated as a result of the first fall.

The home's policy "Head Trauma", directed staff to initiate head injury routine when there was trauma to a resident's head. The assessment was to include complete vital signs and complete neurological signs to be completed at the time of the injury, in one hours' time, every two hours for four times, if stable then every shift for 72 hours.

A review of the HIR with RN #119 revealed that one HIR form was completed with both times of fall noted at the top. The document was acknowledged to be incomplete.

c) On a specific date in 2018, resident #025 fell and a HIR was initiated.

A review of the clinical record noted that the HIR was incomplete. During an interview with RN #119 they acknowledged that the HIR record was incomplete.

Registered Nurse #119 acknowledged that staff did not follow the "Head Trauma" policy for residents #017, #022 and #025 as they did not assess the resident as per the home's policy for all required timelines. [s. 8. (1) (b)]

Additional Required Actions:

CO # - 004 will be served on the licensee. Refer to the "Order(s) of the Inspector".

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that the home's policy "Pain Management", reference # PM-01, is in compliance with and was implemented in accordance with applicable requirements under the Act, to be implemented voluntarily.

WN #5: The Licensee has failed to comply with O.Reg 79/10, s. 54. Altercations and other interactions between residents
Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Findings/Faits saillants :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

a) On a specific date in 2017, a CI report was submitted to the MOHLTC indicating that a physical altercation took place between residents #013 and #015 which resulted in injury to resident #015. A similar incident occurred later in 2017, where both residents again had a physical altercation.

Resident #013's clinical records indicated that the resident had a history of responsive behaviours.

Resident #013 and #015 had their rooms near each other until 2018. On two separate occasions in 2017, resident #013 had an altercation with resident #015.

A review of resident #013's progress notes identified that there were three similar incidents that took place between both residents in approximately a one month

period. There was no documentation to indicate that interventions were developed and implemented after each incident to minimize the risk of altercations between the two residents.

The BSO team lead stated that it was their expectation that after any physical altercation, residents were assessed and interventions were developed and implemented to prevent recurrence. They acknowledged that after each incident, no steps were taken to minimize the risk of altercations and potentially harmful interactions between residents #013 and #015 by identifying and implementing interventions.

b) A CI report was submitted by the home to the MOHLTC stating that resident #014 and resident #015 had an altercation.

A record review revealed that resident #014 had at least three similar incidences of altercation with resident #015 in approximately a two month period. After each incident, there was no documentation to indicate that interventions were developed and implemented to minimize the risk of altercations between the two residents.

RN #119 acknowledged that no interventions were developed and put in place after each altercation that took place between the two residents.

The home has failed to ensure that that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents #013 and #015, and between residents #014 and #015, by identifying and implementing interventions. [s. 54. (b)]

Additional Required Actions:

CO # - 005 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #6: The Licensee has failed to comply with O.Reg 79/10, s. 110. Requirements relating to restraining by a physical device

Specifically failed to comply with the following:

s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. O. Reg. 79/10, s. 110 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident was monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

a) Resident #012 had a restraint implemented on a specific date in 2016, as per the physician's order.

On two separate occasions, the LTCH Inspector observed the resident with the restraint.

The resident's plan of care directed staff to monitor the resident's restraint for safety/comfort and for correct application, every two hours. On alternate two hours, staff were directed to check for safety/comfort, release and reposition the resident which resulted in hourly checks of the resident. On several occasions where the resident was required to be checked and/or repositioned during a specific month in 2018, there was no documentation to indicate this had been completed.

The DOC stated it was an expectation that when staff completed the task of checking for safety, comfort and/or repositioning of a resident on an hourly basis, that had a restraint in place, that they document their actions in the electronic clinical record.

The DOC acknowledged that on several occasions during a specific month in 2018, staff failed to monitor the resident every hour.

b) As part of an inspection related to a CI report, the LTCH Inspector reviewed the fall described in the report and the two falls that occurred the previous day.

Minimum Data Set (MDS) assessment dated August 8, 2017, assessed the resident as having cognitive deficits and requiring assistance with activities of daily living.

The resident's plan of care indicated that on a specific date in 2017, a restraint was implemented.

The following day, the resident had the restraint in place but was found on the floor with a significant injury.

The LTCH Inspector reviewed resident #017's clinical record and was not able to locate any "Restraint Monitoring Record". There were no notes in the electronic record and the electronic monitoring record was not in place at the time of the implementation of the restraint, according to RN #125.

The written plan of care for resident #017 directed staff to release and reposition the resident every two hours.

During an interview with RN #125, they stated the "Restraint Monitoring Record" would have been kept in the restraint binder at the time but the home had since changed their practice. The RN stated all forms and consents should be part of the clinical record. The RN and the LTCH Inspector reviewed the clinical record and there were no "Restraint Monitoring Records" related to the implementation of the restraint.

The RN stated it was an expectation of the home that any resident with a restraint was to be monitored every hour and that the monitoring was to be documented.

The RN acknowledged there was no documentation of any hourly monitoring of the lap belt restraint for resident #017.

c) Resident #019 had a restraint implemented on a specific date in 2018.

The LTCH Inspector observed the resident with their restraint on.

The LTCH Inspector reviewed the resident's plan of care for a specific month in 2018 and on several occasions where the resident was required to be checked and/or repositioned there was no documentation to indicate this had been completed.

The DOC acknowledged that on several occasions during a specific month in 2018, staff failed to monitor the resident every hour.

The licensee failed to ensure that residents #012, #017, and #019, who were restrained by a physical device, were monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. [s. 110. (2) 3.]

Additional Required Actions:

CO # - 006 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #7: The Licensee has failed to comply with O.Reg 79/10, s. 15. Bed rails

Specifically failed to comply with the following:

s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,
(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident; O. Reg. 79/10, s. 15 (1).
(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and O. Reg. 79/10, s. 15 (1).
(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that where bed rails were used, the resident was assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident.

a) During stage one of the RQI, Resident #010's bed rails were triggered for inspection. The resident received a new bed with bed rails in 2018.

Personal Support Worker #109 informed the LTCH Inspector that the bed rails are always in the "up" position, and that the resident would use them when needed in bed.

Registered Nurse #103 confirmed that the resident had bed rails and that there was no assessment completed after the new bed was installed with the rails.

The DOC acknowledged that no bed rail assessment was completed after the new bed with new bed rails were put in place.

b) Resident #003 received a new bed with bed rails in 2018.

Personal Support Worker #109 informed the LTCH Inspector that the bed rails were always in the "up" position, and that the resident used them when needed in bed.

Registered Nurse #103 confirmed that the resident had bed rails and that there was no assessment completed after the new bed was installed with the bed rails.

The DOC acknowledged that no bed rail assessment was completed after the new bed with new bed rails were put in place.

The licensee has failed to ensure that where bed rails were used for residents #010 and #003, the residents had been assessed and their bed systems evaluated in accordance with evidence-based practices, and if there were none, in accordance with prevailing practices to minimize risk to the resident. [s. 15. (1) (a)]

2. The licensee has failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

a) During stage one of the RQI, resident #008 was triggered for a possible bed rail accident hazard.

The LTCH Inspector observed resident #008's bed with bed rails raised. The residents bed had a gap between the mattress and the wooden frame at the head of the bed.

An entrapment report completed for resident #008's bed indicated that the resident's bed failed the entrapment assessment.

The DOC confirmed that resident #008's bed failed the entrapment assessment and that no further steps were taken to resolve the problem.

b) During stage one of the RQI, resident #007 was triggered for a possible bed rail accident hazard.

The LTCH Inspector observed resident #007's bed with two bed rails raised. The residents bed had a gap between the mattress and the wooden frame at the head of the bed.

An entrapment report completed for resident #007's bed indicated that the bed failed the entrapment assessment.

The DOC confirmed that resident #007's bed failed the entrapment inspection and that nothing was done to resolve the issue.

The licensee has failed to ensure that where bed rails were used for resident #008 and #007, steps were taken to prevent resident entrapment. [s. 15. (1) (b)]

Additional Required Actions:

CO # - 007 will be served on the licensee. Refer to the "Order(s) of the Inspector".

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that where bed rails are used, the resident has been assessed and his or her bed system evaluated in accordance with evidence-based practices, and if there are none, in accordance with prevailing practices to minimize risk to the resident, to be implemented voluntarily.

WN #8: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that the care set out in the plan of care was provided to the resident as specified in the plan.

a) Resident #018's plan of care was reviewed related to a CI report wherein the resident fell which resulted in an injury.

During a review of the resident's plan of care, in place at the time of the fall, it provided direction for when to toilet the resident and checking on the resident hourly.

During an interview with PSW #127 and #106, they told the LTCH Inspector that they were not sure if or where the falls interventions were to be documented at the time. Neither could recall what the interventions were at the time. Both PSWs stated they did not toilet the resident at the required time specified in the written plan of care.

During an interview with RN #125, they acknowledged the home failed to ensure that care was provided to the resident to include the toileting at specific times and checking the resident hourly as the home did not have any documentation to confirm this occurred.

Registered Nurse #125 acknowledged the care set out in the plan of care was not provided to resident #018.

b) On a specific date in 2018, resident #019 had a restraint implemented. At the time of this inspection, the restraint remained in place.

The LTCH Inspector observed the resident with their restraint in place.

The LTCH Inspector reviewed the plan of care in place and noted it directed staff to complete a monthly restraint assessment. The MAR was also reviewed and it directed staff to complete a monthly assessment of the restraint use at monthly intervals.

The LTCH Inspector reviewed the clinical record for a one year period and found that for five months, the resident's restraint use was not assessed as per the plan of care.

During an interview with RN #119, they told the LTCH Inspector it was an expectation of the home that every month, a monthly restraint assessment was to be completed for each resident who had a restraint in place.

The clinical record was reviewed with the RN and they acknowledged that on five occasions, the monthly restraint assessment was not completed as per the plan of care.

c) On a specific date in 2018, resident #012 had a restraint implemented. At the time of this inspection, the restraint remained in place.

The LTCH Inspector observed the resident with the restraint in place.

The LTCH Inspector reviewed the plan of care in place and noted it directed staff to complete a monthly restraint assessment for the restraint. The MAR was also reviewed and it directed staff to complete a monthly assessment of the restraint use on a specific day every month.

The LTCH Inspector reviewed the clinical record for a one year period and found that for five months the resident's restraint use was not assessed as per the plan of care.

During an interview with RN #119, they told the LTCH Inspector it was an expectation of the home that every month, a monthly restraint assessment was to be completed for each resident who had a restraint in place.

The clinical record was reviewed with the RN and they acknowledged that on five occasions, the monthly restraint assessment was not completed as per the plan of care.

The licensee failed to ensure that the care set out in the plans of care for residents #018, #019, and #012, was provided to the residents as specified in the plans. [s. 6. (7)]

2. The licensee has failed to ensure that the resident was reassessed and the plan of care was reviewed and revised at least every six months and at any other time when the resident's care needs had changed or care set out in the plan was no longer necessary.

a) A complaint was submitted to the MOHLTC stating that resident #008 had acquired an area of altered skin integrity as a result of the application of a device. The complainant indicated that the resident had the device on for approximately six weeks, and it was not removed despite the resident complaining of pain and swelling.

The LTCH Inspector reviewed the clinical record of resident #008 and found that the resident had a fall which resulted in injury.

A couple of days later, a progress note was written by RN #119 stating that the resident returned from the clinic with a device on a specific area of their body. Upon return, the resident's family member gave instructions to RN #119 that were provided to them at the clinic. The instructions included that the device should be removed for a specific period of time everyday and to check to ensure it was on properly.

Registered Practical Nurse #105 and #111 reviewed the plan of care for resident #008 and stated that it was not reviewed and revised to include instructions for the device.

Registered Nurse #119 told the LTCH inspector that it was the home's practice that any recommendations from the outpatient clinic should be communicated to the home's physician and reflected under the resident's plan of care. They acknowledged that they did not review and revise resident #008's plan of care when the resident's care needs had changed.

b) During stage one of the RQI, the MDS-RAI was triggered for Resident #012's communication and hearing.

Resident #012's plan of care indicated that the resident had an assistive device for hearing and to report if they were missing to ensure a thorough search could have been conducted.

The LTCH Inspector observed resident #012 on two separate conditions, without their assistive device.

Personal Support Worker #106 informed the LTCH Inspector that they cannot remember the last time resident #012 had the assistive device but believed it was

more than a year ago. Personal Support worker #108 did not recall the resident having the assistive device at all.

Registered Practical Nurse #105 confirmed that the resident no longer had the assistive device and that the written plan of care should have been updated to reflect this.

The licensee has failed to ensure that residents #008 and #012 were reassessed and the plans of care were reviewed and revised at least every six months and at any other time when the resident's care needs had changed or care set out in the plans were no longer necessary. [s. 6. (10) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that:
a) the care set out in the plan of care is provided to the resident as specified in the plan
b) the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when the resident's care needs have changed or care set out in the plan was no longer necessary, to be implemented voluntarily.

WN #9: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 24. Reporting certain matters to Director

Specifically failed to comply with the following:

s. 24. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:
1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
2. Abuse of a resident by anyone or neglect of a resident by the licensee or staff that resulted in harm or a risk of harm to the resident. 2007, c. 8, s. 24 (1), 195 (2).
3. Unlawful conduct that resulted in harm or a risk of harm to a resident. 2007, c. 8, s. 24 (1), 195 (2).
4. Misuse or misappropriation of a resident's money. 2007, c. 8, s. 24 (1), 195 (2).
5. Misuse or misappropriation of funding provided to a licensee under this Act or the Local Health System Integration Act, 2006. 2007, c. 8, s. 24 (1), 195 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that the person who had reasonable grounds to suspect that abuse of a resident by anyone that resulted in harm or risk of harm has occurred or may occur, has immediately reported the suspicion and the information upon which it was based to the Director.

a) During stage one of the Resident Quality Inspection (RQI), resident #003 informed the LTCH Inspector that they experienced altered skin integrity after PSW #117 treated them roughly during care.

Resident #003 stated that they told registered staff about what happened and that the same PSW has been rough with them in the past.

A record review was conducted and on a specific date in 2018, Registered Practical Nurse (RPN) #110 documented that resident #003 showed them an area of altered skin integrity and indicated that it was caused by a staff member during care.

Registered Practical Nurse (RPN) #110, acknowledged that the resident informed them they were abused by a PSW and that they informed RN #122.

The DOC acknowledged that the alleged abuse was not reported to the Director.

b) A CI report was submitted to the MOHLTC which stated that resident #022 was allegedly sexually abused by resident #014.

A review of the home's risk management tab on Point Click Care (PCC) and resident #015 and #027's clinical records did not show any written documentation to support that the home had immediately reported the incident of alleged physical abuse to the Director.

RN #119 told the LTCH Inspector that this incident was considered resident to resident sexual abuse and such incidents needed to be reported immediately to the Director.

The DOC acknowledged that they failed to report this incident immediately to the Director.

c) In stage one of the RQI, resident #010 informed the LTCH Inspector that they were mistreated by PSW #114 during care several months ago.

Resident #010 described feeling humiliated, expressing that they felt helpless and hurt that they were viewed as just a job. The resident described feeling ignored, not knowing whether the staff were returning after leaving in the middle of their care.

Upon review of the home's investigation notes, it indicated that the resident was emotionally affected the morning after the incident. The resident reported to the DOC that something occurred the evening before. The resident indicated feeling excluded during care and that the staff left the room in the middle of providing care. The resident expressed feeling treated without dignity. The DOC concluded the investigation notes by indicating that they spoke with PSW #114 about their behaviour and that it could be viewed as abuse.

The DOC confirmed in an interview that this incident was not reported to the Director.

The licensee has failed to ensure that when there were reasonable grounds to suspect that abuse towards residents #010, #027, and #003 had occurred, that the suspicion was immediately reported to the Director. [s. 24. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that when there is reasonable grounds to suspect that abuse of a resident by anyone occurred, that the suspicion is immediately reported to the Director, to be implemented voluntarily.

WN #10: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care
Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
8. Continence, including bladder and bowel elimination. O. Reg. 79/10, s. 26 (3).

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's continence, including bladder and bowel elimination.

A complaint was received by the MOHLTC regarding resident #016's toileting routine and patterns during a specific month in 2017.

According to the MDS on a specific date in 2017, resident #016 was assessed for continence of bowel. A record review of the written plan of care from a specific date in 2017, did not indicate whether the resident was continent or incontinent of

bowels.

Personal Support Worker #132 was able to describe the residents continence in that period of time in 2017. They also indicated that if a resident was incontinent they would know this as it would be indicated in Point of Care (POC) or in the residents plan of care.

Resident Clinical Coordinator (RCC) #124 indicated to the LTCH Inspector that it was unclear whether the resident was continent of bowels during that time period as it was not indicated in the written plan of care in that specific time in 2017.

The licensee failed to ensure that the plan of care plan was based on an interdisciplinary assessment of resident #016's continence in relation to bowel elimination. [s. 26. (3) 8.]

2. The licensee has failed to ensure that the plan of care was based on an interdisciplinary assessment of the resident's sleep patterns and preferences.

a) On two separate occasions in 2018, the LTCH inspector observed resident #007 sleeping.

Resident #007's most current written plan of care was reviewed and did not include their sleep patterns and preferences.

Personal Support Worker #104 told the LTCH inspector that resident #007 would go to bed at a specific time in the evening and usually wake up at a specific time in the morning. They added that if the resident was sleepy in between then they would put them back in bed but it varied from day to day.

Personal Support Worker #104 and RN #112 reviewed resident #007's plan of care and acknowledged that it did not identify resident's sleep patterns and preferences.

b) Resident #005 was identified as being bed fast all or most of the time according to the most recent Minimum Data Set (MDS) assessment dated in 2018.

On October 17 and 18, 2018, the LTCH Inspector observed resident #005 sleeping in their bed.

Personal Support Worker #104 stated that resident #005 was put to bed every day for a specific period of time for a morning nap. The resident would sleep again at a specific time in the evening.

The LTCH Inspector reviewed the clinical records for resident #005 including written plan of care and was unable to locate the sleep patterns and preferences for the resident.

Registered Practical Nurse #103 acknowledged resident #005 did not have any sleep patterns and preferences identified in their plan of care.

c) On a specific date at a specific time, the LTCH inspector observed resident #011 sleeping.

Resident #011's most current written plan of care was reviewed and did not include the resident's sleep patterns and preferences.

Personal Support Worker #107 told the LTCH inspector that resident #011 would go to bed at specific times during the day and usually sleep throughout the night.

Personal Support Worker #107 and RPN #105 reviewed the resident's plan of care and acknowledged that it did not include sleep patterns and preferences.

d) A complaint was submitted to the MOHLTC in 2017 regarding resident #016 not being put to bed at the requested and preferred bed time. The complainant described an incident where the resident was not put to bed until more than an hour later.

The complaints that were submitted to the home in 2017 were reviewed and it was identified that earlier in 2017, a similar complaint was received for this resident by the home. The action plan from the home stated that they would try to ensure that resident #016 was assisted to bed at the requested time when possible.

Personal Support Worker #133 stated that in that time period of 2017, they were able to recall what the residents bedtime was.

Registered Practical Nurse #110, acknowledged that the sleeping patterns of a

resident, including their bedtime, should be indicated in the written plan of care. The RPN acknowledged that in the specified period of time in 2017, there was no indication in the written plan of care regarding the resident's sleep patterns.

The home has failed to ensure that a plan of care was based on, at a minimum, an interdisciplinary assessment of sleep and rest patterns with respect to residents #016, #011, #007, and #005. [s. 26. (3) 21.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the plan of care plan was based on an interdisciplinary assessment of the resident's sleep patterns and preferences, to be implemented voluntarily.

WN #11: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 29. Policy to minimize restraining of residents, etc.

Specifically failed to comply with the following:

s. 29. (1) Every licensee of a long-term care home,
(a) shall ensure that there is a written policy to minimize the restraining of residents and to ensure that any restraining that is necessary is done in accordance with this Act and the regulations; and 2007, c. 8, s. 29 (1).
(b) shall ensure that the policy is complied with. 2007, c. 8, s. 29 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written policy to minimize the restraining of residents and to ensure that any restraining that was necessary was done in accordance with the Act and the regulations and was complied with.

a) Resident #012 had a restraint implemented in 2016, as per the physician's order.

The LTCH Inspector observed the resident with the restraint implemented.

The clinical record was reviewed for resident #012 and noted that the consent from the SDM was renewed in 2018.

The home's policy "Least Restraint Care", directed that a written consent was required to be obtained from the resident or SDM at a minimum of annually.

RN #119 informed the LTCH Inspector it was expected that an annual consent was required from the resident or SDM for any restraint.

Registered Nurse #119 acknowledged that the consent from resident #012 was not obtained annually and the home had not followed their policy "Least Restraint Care".

b) As a result of an inspection related to a CI report, the LTCH Inspector reviewed the fall described in the report and the two falls that occurred the previous day for resident #017.

The resident's plan of care indicated that on on a specific date in 2017, a restraint was implemented.

The home's policy "Least Restraint Care", directed that there be a physician's order in writing and that the order may not be for "as needed" (prn) use.

The LTCH Inspector reviewed the "Physician's Order for Restraint/PASD" form signed by the resident's physician. The type of safety device was noted to be a specific restraint – prn.

During an interview with the DOC they stated that a restraint may not be ordered as a prn.

The DOC acknowledged that the order for the restraint for resident #017 did not comply with the home's restraint policy in place at the time of the implementation of the restraint.

c) Resident #019 had a restraint implemented on on a specific date in 2018.

The home's policy "Least Restraint Care", directed staff to ensure an initial assessment for the restraint use was completed prior to the initiation of the restraint.

The clinical record for resident #019 was reviewed and noted the resident did not have an assessment related to the implementation of the restraint.

Registered Nurse #125 stated that this resident did not have an initial assessment completed prior to the implementation of this particular restraint.

Registered Nurse #125 acknowledged there was no initial assessment completed related to the implementation of the restraint as per the home's policy.

The licensee failed to ensure that the written policy to minimize the restraining of residents and to ensure that any restraining that was necessary was done in accordance with the Act and the regulations and was complied with for resident's #012, #017 and #019. [s. 29. (1) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the written policy to minimize the restraining of residents and to ensure that any restraining that was necessary was done in accordance with the Act and the regulations and was complied with, to be implemented voluntarily.

WN #12: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 31. Restraining by physical devices

Specifically failed to comply with the following:

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
2. Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk referred to in paragraph 1. 2007, c. 8, s. 31 (2).

s. 31. (2) The restraining of a resident by a physical device may be included in a resident's plan of care only if all of the following are satisfied:
5. The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision-maker of the resident with authority to give that consent. 2007, c. 8, s. 31 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that the restraining of a resident by a physical device was included in the resident's plan of care only if alternatives to restraining the resident had been considered, and tried where appropriate, but would not be, or had not been, effective to address the risk.

As part of an inspection related to a CI report, the LTCH Inspector reviewed the fall described in the report and the two falls that occurred the previous day.

Resident #017's plan of care indicated that on a specific date in 2017, a restraint was implemented.

The home's policy "Least Restraint Care", directed staff to ensure that all possible alternative interventions were to be exhausted prior to deciding to use a restraint. Also that before a restraint was considered, all feasible alternatives would have been tried and documented.

During an interview with RN #125, they told the LTCH Inspector that it was an expectation that alternatives to restraining were to have been trialed prior to implementing a restraint for this resident.

The LTCH Inspector reviewed the resident's clinical record and was not able to locate any documentation that any alternatives to restraining had been implemented prior to the implementation of the restraint.

RN #125 acknowledged there were no notes or other documentation to validate or confirm that alternatives to a restraint were trialed for resident #017 prior to implementing the restraint. [s. 31. (2) 2.]

2. The licensee failed to ensure that the restraining of the resident had been consented to by the resident or, if the resident was incapable, a substitute decision-maker of the resident with authority to give the consent.

Resident #017's plan of care indicated that on a specific date in 2017, a restraint was implemented.

The LTCH Inspector reviewed resident #017's clinical record and was not able to locate a consent for the use of the restraint.

The written plan of care for resident #017 directed staff to obtain consent for the restraint from the resident's SDM.

During an interview with RN #125, they stated the consent would have been kept in the restraint binder at the time but the home had since changed their practice. The RN stated all forms and consents should be part of the clinical record.

The RN reviewed the clinical record and acknowledged there was no consent for the implementation of the restraint for resident #017. [s. 31. (2) 5.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the restraining of a resident by a physical device is included in the resident's plan of care only if:
a) Alternatives to restraining the resident have been considered, and tried where appropriate, but would not be, or have not been, effective to address the risk,

b) The restraining of the resident has been consented to by the resident or, if the resident is incapable, a substitute decision maker of the resident with authority to give that consent, to be implemented voluntarily.

WN #13: The Licensee has failed to comply with O.Reg 79/10, s. 50. Skin and wound care

Specifically failed to comply with the following:

s. 50. (2) Every licensee of a long-term care home shall ensure that,
(b) a resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds,
(i) receives a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,
(ii) receives immediate treatment and interventions to reduce or relieve pain, promote healing, and prevent infection, as required,
(iii) is assessed by a registered dietitian who is a member of the staff of the home, and any changes made to the resident's plan of care relating to nutrition and hydration are implemented, and
(iv) is reassessed at least weekly by a member of the registered nursing staff, if clinically indicated; O. Reg. 79/10, s. 50 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that residents who exhibited altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment.

The LTCH Inspector observed an area of altered skin integrity on resident #003 in stage one of the RQI. The resident stated that they had informed a nurse a few weeks earlier.

Upon record review, a progress note was identified on a specific date by PSW #117 that indicated that resident #003 had altered skin integrity but did not indicate the location. Two days later, RPN #110 documented that resident #003 showed the RPN an area of altered skin integrity. Upon further review of the residents clinical record, the LTCH Inspector did not find a clinically appropriate assessment instrument that was specifically designed for skin and wound completed for the new area of altered skin integrity.

Registered Nurse #119 reviewed the progress notes from the two dates and confirmed that an assessment should have been completed and that an assessment was not completed for resident #003 after the new area of altered skin integrity was identified.

The licensee has failed to ensure that resident #003 who exhibited altered skin integrity received a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that was specifically designed for skin and wound assessment. [s. 50. (2) (b) (i)]

2. The licensee has failed to ensure that the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated.

During stage one of the RQI, resident #008 was triggered as having an area of altered skin integrity.

Resident #008's clinical record indicated that on on a specific date in 2018, the resident was found with an area of altered skin integrity.

Registered Practical Nurse #105 and #111 told the LTCH Inspector that any resident who has been identified with a skin integrity impairment was to be assessed on a weekly basis using the weekly skin/wound assessment form in PCC.

A review of resident #008's weekly skin/wound assessments revealed that there was no assessment completed on five occasions where it was expected to be completed.

Registered Practical Nurse #105, the home's skin and wound care lead, reviewed resident #008's weekly skin assessment in PCC and acknowledged that weekly skin assessments were not completed on five occasions where it was expected to be completed.

The home had failed to ensure that resident #008 who was exhibiting altered skin integrity was reassessed at least weekly by a member of the registered nursing staff. [s. 50. (2) (b) (iv)] (696) [s. 50. (2) (b) (iv)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that:
a) residents exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, receive a skin assessment by a member of the registered nursing staff, using a clinically appropriate assessment instrument that is specifically designed for skin and wound assessment,

b) the resident exhibiting altered skin integrity, including skin breakdown, pressure ulcers, skin tears or wounds, had been reassessed at least weekly by a member of the registered nursing staff, if clinically indicated, to be implemented voluntarily.

WN #14: The Licensee has failed to comply with O.Reg 79/10, s. 53. Responsive behaviours

Specifically failed to comply with the following:

s. 53. (3) The licensee shall ensure that,
(a) the matters referred to in subsection (1) are developed and implemented in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; O. Reg. 79/10, s. 53 (3).
(b) at least annually, the matters referred to in subsection (1) are evaluated and updated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices; and O. Reg. 79/10, s. 53 (3).
(c) a written record is kept relating to each evaluation under clause (b) that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 53 (3).

s. 53. (4) The licensee shall ensure that, for each resident demonstrating responsive behaviours,
(a) the behavioural triggers for the resident are identified, where possible; O. Reg. 79/10, s. 53 (4).
(b) strategies are developed and implemented to respond to these behaviours, where possible; and O. Reg. 79/10, s. 53 (4).
(c) actions are taken to respond to the needs of the resident, including assessments, reassessments and interventions and that the resident's responses to interventions are documented. O. Reg. 79/10, s. 53 (4).

Findings/Faits saillants :

1. The licensee has failed to ensure that the written record relating to the Responsive Behaviour program evaluation included the date of the evaluation, names of the persons who participated, summary of the changes made, and date that those changes were implemented.

The home's annual evaluation for the Responsive Behaviour program was reviewed.

The written record did not include the date when the changes were implemented for the Responsive Behaviour program.

The Executive Director (ED) acknowledged that the written record relating to the Responsive Behaviour program evaluation did not include the dates when the

changes were implemented. [s. 53. (3) (c)]

2. The licensee has failed to ensure that the behavioural triggers had been identified for the resident demonstrating responsive behaviours, where possible.

a) Resident #013 had a medical diagnosis and cognitive deficits.

The clinical record of resident #013 was reviewed and indicated that they exhibited responsive behaviours in a period of three months in 2017.

The Dementia Observation Scale (DOS) was initiated for resident #013 in that time for the period of two weeks, however there was no analysis of the DOS documented. There was no other documentation in the resident's clinical record which identified the possible behavioural triggers for their behaviours.

Personal Support Worker #106 and RPN #100 were both unaware of what triggered resident #013's responsive behaviours.

Registered Practical Nurse #100 reviewed the most current plan of care for resident #013 and stated that there were no behavioural triggers identified in it.

Behavoural Support Ontario (BSO) team lead stated that if a resident continuously exhibited responsive behaviours then Dementia Observation Scale (DOS) would be initiated and analyzed to identify the resident's behavioural triggers. They acknowledged that behavioural triggers were not identified for resident #013's behaviours.

b) Resident #014 had a medical diagnosis and cognitive deficits.

The clinical record for resident #014 was reviewed and indicated that they had history of responsive behaviours. There was no documentation in the resident's clinical record which identified the possible triggers for the resident's responsive behaviours.

There were no triggers identified on the resident's current responsive behaviour plan of care.

Personal Support Worker #108 and RN #119 were unaware of what triggered the resident's responsive behaviours.

Registered Nurse #119 acknowledged that resident #014's behavioural triggers had not been identified.

The home has failed to ensure that behavioural triggers were identified for resident #013 and #014 who exhibited responsive behaviours. [s. 53. (4) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that the behavioural triggers have been identified for the resident demonstrating responsive behaviours, where possible, to be implemented voluntarily.

WN #15: The Licensee has failed to comply with O.Reg 79/10, s. 129. Safe storage of drugs

Specifically failed to comply with the following:

s. 129. (1) Every licensee of a long-term care home shall ensure that,
(a) drugs are stored in an area or a medication cart,
(i) that is used exclusively for drugs and drug-related supplies,
(ii) that is secure and locked,
(iii) that protects the drugs from heat, light, humidity or other environmental conditions in order to maintain efficacy, and
(iv) that complies with manufacturer's instructions for the storage of the drugs; and O. Reg. 79/10, s. 129 (1).
(b) controlled substances are stored in a separate, double-locked stationary cupboard in the locked area or stored in a separate locked area within the locked medication cart. O. Reg. 79/10, s. 129 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were stored in an area or medication cart that was secure and locked.

During stage one of the RQI, the LTCH Inspector interviewed resident #021.

During the interview, the LTCH Inspector observed a bottle of medication on the resident's side table. When asked, the resident did not know what it was, why it was there or who it belonged to.

The LTCH Inspector observed it to be a specific type of medication and was labeled with resident #021's name and directions to administer.

Registered Practical Nurse #100, who was responsible for administering medications to this resident, stated the medication was left in error and should have been returned to the locked medication cart.

RPN #100 acknowledged the medication was not stored in the medication cart that was secure and locked. [s. 129. (1) (a)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that drugs are stored in an area or medication cart that is secure and locked, to be implemented voluntarily.

WN #16: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (2) The licensee shall ensure that drugs are administered to residents in accordance with the directions for use specified by the prescriber. O. Reg. 79/10, s. 131 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that drugs were administered to residents in accordance with the directions for use specified by the prescriber.

a) The medication incident on a specific date in 2018, stated that at a specific time, resident #021 was administered their prescribed medications that were directed to be given at several different times throughout the day all at once.

The LTCH Inspector reviewed the residents clinical record to include the Medication Administration Record (MAR) and found that several different medications and doses were administered at once that were expected to be administered throughout the day.

Registered Nurse #121 stated that they had been notified by RPN #100, who was involved in the incident, of the occurrence. When they interviewed RPN #100, they stated they had opened the first one, was distracted, then returned to the cart, opened all remaining pouches for that day, and proceeded to administer them to resident #021.

The DOC acknowledged that RPN #100 administered medications to a resident that was not in accordance with the directions for use as specified by the prescriber.

b) On a specific date in 2018, RN #122 administered evening medications in a specific home area. Based on a medication incident, the LTCH Inspector reviewed a report run in Point Click Care (PCC), the home's electronic documentation system, that identified that resident #008 was administered all of their evening medications two hours after they were due.

The clinical record was reviewed and there was no documentation of any explanation or new orders from the physician to alter the time of the medication administration for two hours later.

The DOC told the LTCH Inspector that it was the expectation of the home that all medications were administered as directed by the physician and a two hour time difference was not acceptable.

The DOC acknowledged that RN #122 did not administer resident #008's evening medications as directed by the prescriber.

The licensee failed to ensure that drugs were administered to residents #008 and #021 in accordance with the directions for use specified by the prescriber. [s. 131. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that drugs are administered to residents in accordance with the directions for use specified by the prescriber, to be implemented voluntarily.

WN #17: The Licensee has failed to comply with O.Reg 79/10, s. 135. Medication incidents and adverse drug reactions

Specifically failed to comply with the following:

s. 135. (1) Every licensee of a long-term care home shall ensure that every medication incident involving a resident and every adverse drug reaction is,
(a) documented, together with a record of the immediate actions taken to assess and maintain the resident's health; and O. Reg. 79/10, s. 135 (1).
(b) reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider. O. Reg. 79/10, s. 135 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that every medication incident involving a resident was reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider.

a) The medication incident on a specific date in 2018, stated that at a specific time, resident #021 was administered their prescribed medications that were directed to be given at several different times throughout the day all at once.

The LTCH Inspector reviewed the residents clinical record to include the MAR and found that several different medications and doses were administered at once that were expected to be administered throughout the day.

The medication incident did not include the notification of the Medical Director, the resident's physician and the pharmacy service provider.

b) On a specific date in 2018, RN #122 documented on the individual resident narcotic sheets that all residents with controlled substance medications at bedtime, on a specific home area, all had the same time of administration.

The medication incident form was not faxed to the pharmacy and during an interview with the pharmacist, they acknowledged they had not received notification of, nor were aware of this incident.

The only person notified was the DOC the following day.

The DOC acknowledged the two incidents above did not notify all those that were required to be notified. [s. 135. (1)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that every medication incident involving a resident is reported to the resident, the resident's substitute decision-maker, if any, the Director of Nursing and Personal Care, the Medical Director, the prescriber of the drug, the resident's attending physician or the registered nurse in the extended class attending the resident and the pharmacy service provider, to be implemented voluntarily.

WN #18: The Licensee has failed to comply with O.Reg 79/10, s. 221. Additional training — direct care staff

Specifically failed to comply with the following:

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
1. Falls prevention and management. O. Reg. 79/10, s. 221 (1).

s. 221. (1) For the purposes of paragraph 6 of subsection 76 (7) of the Act, the following are other areas in which training shall be provided to all staff who provide direct care to residents:
3. Continence care and bowel management. O. Reg. 79/10, s. 221 (1).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).
2. If the licensee assesses the individual training needs of a staff member, the staff member is only required to receive training based on his or her assessed needs. O. Reg. 79/10, s. 221 (2).

s. 221. (2) The licensee shall ensure that all staff who provide direct care to residents receive the training provided for in subsection 76 (7) of the Act based on the following:
1. Subject to paragraph 2, the staff must receive annual training in all the areas required under subsection 76 (7) of the Act. O. Reg. 79/10, s. 221 (2).

s. 221. (3) The licensee shall ensure that the training required under paragraph 2 of subsection 76 (7) of the Act includes training in techniques and approaches related to responsive behaviours. O. Reg. 79/10, s. 221 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that training in falls prevention and management was provided to all staff who provide direct care to residents.

For the 2017 calendar year, five percent (%) of registered staff and 12% of PSWs did not receive falls prevention and management training.

The DOC acknowledged that not all required staff were provided training for falls prevention and management in 2017. [s. 221. (1) 1.]

2. The licensee failed to ensure that training in continence care and bowel management was provided to all staff who provide direct care to residents.

During the RQI Inspection, the LTCH Inspector reviewed with the DOC, the home's education and training for continence care and bowel management.

The DOC acknowledged training was not provided to direct care staff for continence care and bowel management. [s. 221. (1) 3.]

3. The licensee has failed to ensure that all staff who provide direct care to residents received annual training in all the areas required for: behaviour management, abuse recognition and prevention, and how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with the Act and regulations.

a) The LTCH Inspector requested documentation for the annual training of the responsive behaviours program for 2017.

The BSO team lead stated that they could not confirm if all direct care staff received the required annual training for the responsive behaviours program last year.

The DOC and Executive Director (ED) of Parkwood Long-Term Care (LTC) acknowledged that they do not have any records or documentation from 2017 to show that all direct care staff received training for the responsive behaviours program.

b) The LTCH Inspector requested training for 2017 related to the zero tolerance for abuse policy. Under the Annual Mandatory Abuse Review Part one and Part two, it indicated that 9% of PSWs and 8% of registered staff did not receive their training in 2017.

The DOC confirmed that not all required staff received training related in abuse recognition and prevention.

c) During an inspection regarding the use of physical restraints, the LTCH

Inspector reviewed the home's required training for staff who apply a restraint or monitor residents restrained by a physical device for the calendar year 2017.

Thirteen percent of registered staff and PSWs were not provided the required training in the application, use and potential dangers of these physical devices during 2017.

The DOC acknowledged that not all required staff received training related to the use of physical restraints and the minimizing of restraints in 2017. [s. 221. (2)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance ensuring that all staff who provide direct care to residents receive annual training in all the areas required for including: falls prevention and management, continence care and bowel management, behaviour management, abuse recognition and prevention, and how to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with the Act and regulations, to be implemented voluntarily.

WN #19: The Licensee has failed to comply with O.Reg 79/10, s. 229. Infection prevention and control program

Specifically failed to comply with the following:

s. 229. (4) The licensee shall ensure that all staff participate in the implementation of the program. O. Reg. 79/10, s. 229 (4).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff participated in the implementation of the program.

On a specific date at a specific time, the LTCH Inspector observed the afternoon snack pass on the Galt home area. Personal Support Worker #129 was serving the snacks.

The LTCH Inspector observed a partly finished meal tray on the top of the snack cart in close proximity to the open snacks and tongs. The tray had a dinner plate on it with a half eaten meal, a used fork and knife, a dirty small bowl with a used spoon in it, and a partly finished drink with a bent straw in the glass.

The PSW told the LTCH Inspector the tray had come from an isolation room from the resident with a contagious medical condition. The PSW confirmed that five residents were served their snack with the used meal tray on the top of the snack cart.

During an interview with RN #119, they told the LTCH Inspector that the used meal tray should not have been on the snack cart. The dishes should have been disposable and left in the garbage in the resident's room, double bagged and then removed.

During an interview with the Nutrition Manager, they stated the dishes were to be disposable and left in the resident's room.

The Nutrition Manager acknowledged the used meal tray should not have been placed on the snack cart during the snack service and that this would be an infection prevention and control breach. [s. 229. (4)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance with ensuring that all staff participated in the implementation of the Infection Prevention and Control program, to be implemented voluntarily.

WN #20: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 22. Licensee to forward complaints

Specifically failed to comply with the following:

s. 22. (1) Every licensee of a long-term care home who receives a written complaint concerning the care of a resident or the operation of the long-term care home shall immediately forward it to the Director. 2007, c. 8, s. 22 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that any written complaints concerning the care of a resident or the operation of the home were forwarded immediately to the Director.

An email was forwarded to the MOHLTC on a specific date in 2018, with a complaint email to the home attached from a specific date in 2017; the complainant indicated that the concerns detailed in the email were still not addressed.

The DOC confirmed that there was no evidence that the written complaint was forwarded to the Director by the home.

The licensee failed to ensure that the written complaint concerning the care of resident #001 and the operation of the home was forwarded immediately to the Director. [s. 22. (1)]

WN #21: The Licensee has failed to comply with O.Reg 79/10, s. 27. Care conference

Specifically failed to comply with the following:

s. 27. (1) Every licensee of a long-term care home shall ensure that,
(a) a care conference of the interdisciplinary team providing a resident's care is held within six weeks following the resident's admission and at least annually after that to discuss the plan of care and any other matters of importance to the resident and his or her substitute decision-maker, if any; O. Reg. 79/10, s. 27 (1).
(b) the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences; and O. Reg. 79/10, s. 27 (1).
(c) a record is kept of the date, the participants and the results of the conferences. O. Reg. 79/10, s. 27 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the resident, the resident's substitute decision-maker, if any, and any person that either of them may direct are given an opportunity to participate fully in the conferences.

One of the concerns expressed by a complainant to the MOHLTC, was that resident #001 was not invited to their admission care conference to discuss the resident's plan of care.

A record review was conducted that found that the residents' care conference was held, the resident was not identified as one of the individuals who was present for the care conference. There was no notes that indicated that the resident was invited to their care conference.

Resident Clinical Coordinator #124 acknowledged that the resident was expected to be invited to their admission care conference and that if a resident was able to participate but refused, they would keep a record of this. The RCC confirmed that there was no indication of whether the resident attended or was invited to their admission care conference.

The licensee failed to ensure that resident #001 was given an opportunity to participate fully in their admission care conference. [s. 27. (1) (b)]

WN #22: The Licensee has failed to comply with O.Reg 79/10, s. 30. General requirements

Specifically failed to comply with the following:

s. 30. (1) Every licensee of a long-term care home shall ensure that the following is complied with in respect of each of the organized programs required under sections 8 to 16 of the Act and each of the interdisciplinary programs required under section 48 of this Regulation:
1. There must be a written description of the program that includes its goals and objectives and relevant policies, procedures and protocols and provides for methods to reduce risk and monitor outcomes, including protocols for the referral of residents to specialized resources where required. O. Reg. 79/10, s. 30 (1).
2. Where, under the program, staff use any equipment, supplies, devices, assistive aids or positioning aids with respect to a resident, the equipment, supplies, devices or aids are appropriate for the resident based on the resident's condition. O. Reg. 79/10, s. 30 (1).
3. The program must be evaluated and updated at least annually in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices. O. Reg. 79/10, s. 30 (1).
4. The licensee shall keep a written record relating to each evaluation under paragraph 3 that includes the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented. O. Reg. 79/10, s. 30 (1).

s. 30. (2) The licensee shall ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions are documented. O. Reg. 79/10, s. 30 (2).

Findings/Faits saillants :

1. The licensee failed to ensure that a written record was kept of the annal reviews for the: a) Continence Care and Bowel Management Program b) Skin and Wound Program and c) Pain Management Program, that included the date of the evaluation, the names of the persons who participated in the evaluation, a summary of the changes made and the date that those changes were implemented.

a) The LTCH Inspector reviewed the 2017 program review of the home's Continence Care and Bowel Management Program dated March 5, 2018. The

review did not include changes made to the program and thus no dates of any changes were identified.

Resident Clinical Coordinator #125, an attendee at the annual review of the program, acknowledged the home failed to ensure that a summary of changes made to the program were identified.

b) The home's annual evaluation for the Pain Management Program was reviewed. The written records did not include the date when the changes were implemented for the Pain Management Program.

The DOC acknowledged that the written record of the annual evaluation for the Pain Management Program did not include the dates when the changes were implemented.

c) The home's annual evaluation related to the Skin and Woundcare Program was reviewed. The written record did not include the date when the changes were implemented for the Skin and Woundcare Program.

The DOC acknowledged that the written record of the annual evaluation for the Skin and Woundcare Program did not include the dates when the changes were implemented.

The licensee failed to ensure that the written record kept of the annal reviews for the: a) Continence Care and Bowel Management Program b) Skin and Woundcare Program and c) Pain Management Program, included a summary of the changes made and/or the date that those changes were implemented. [s. 30. (1) 4.]

2. The license failed to ensure that any actions taken with respect to a resident under a program, including assessments, reassessments, interventions and the resident's responses to interventions were documented.

A CI report was submitted to the MOHLTC wherein resident #018 fell on specific date in 2017, which resulted in an injury.

On a specific date in 2018, resident #018's room was observed by the LTCH Inspector to have an assistive device on the bed.

PSW #127 told the LTCH Inspector, that after placing the resident in bed, they apply the assistive device to ensure the resident did not wiggle to the edge of the bed. They stated the assistive device was implemented a long time ago but could not recall an exact date. They stated they do not document the use of the assistive device.

RPN #105 stated that the resident used the assistive device to ensure they did not fall from the bed.

The plan of care in place following the fall and in place at the time of the inspection was reviewed and did not include the use of the assistive device.

RCC #125 stated that the fall prevention strategies implemented upon return from hospital following the fall included numerous interventions. They did not include the use of the assistive device.

The DOC told the LTCH Inspector the use of the assistive device for resident #018 was expected to be included in the plan of care.

The DOC acknowledged the home had not documented the intervention of using the assistive device to keep the resident from falling out of their bed. [s. 30. (2)]

WN #23: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 76. Training

Specifically failed to comply with the following:

s. 76. (2) Every licensee shall ensure that no person mentioned in subsection (1) performs their responsibilities before receiving training in the areas mentioned below:
1. The Residents' Bill of Rights. 2007, c. 8, s. 76. (2).
2. The long-term care home's mission statement. 2007, c. 8, s. 76. (2).
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents. 2007, c. 8, s. 76. (2).
4. The duty under section 24 to make mandatory reports. 2007, c. 8, s. 76. (2).
5. The protections afforded by section 26. 2007, c. 8, s. 76. (2).
6. The long-term care home's policy to minimize the restraining of residents. 2007, c. 8, s. 76. (2).
7. Fire prevention and safety. 2007, c. 8, s. 76. (2).
8. Emergency and evacuation procedures. 2007, c. 8, s. 76. (2).
9. Infection prevention and control. 2007, c. 8, s. 76. (2).
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee, that are relevant to the person's responsibilities. 2007, c. 8, s. 76. (2).
11. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (2).

s. 76. (7) Every licensee shall ensure that all staff who provide direct care to residents receive, as a condition of continuing to have contact with residents, training in the areas set out in the following paragraphs, at times or at intervals provided for in the regulations:
1. Abuse recognition and prevention. 2007, c. 8, s. 76. (7).
2. Mental health issues, including caring for persons with dementia. 2007, c. 8, s. 76. (7).
3. Behaviour management. 2007, c. 8, s. 76. (7).
4. How to minimize the restraining of residents and, where restraining is necessary, how to do so in accordance with this Act and the regulations. 2007, c. 8, s. 76. (7).
5. Palliative care. 2007, c. 8, s. 76. (7).
6. Any other areas provided for in the regulations. 2007, c. 8, s. 76. (7).

Findings/Faits saillants :

1. The licensee failed to ensure that all staff at the home received training prior to performing their responsibilities in the areas mentioned below:

1. The Resident's Bill of Rights.
2. The long-term care home's mission statement.
3. The long-term care home's policy to promote zero tolerance of abuse and neglect of residents.
4. The duty under section 24 to make mandatory reports.
5. The protection afforded by section 26.
6. The long-term care home's policy to minimize the restraining of residents.
7. Fire prevention and safety.
8. Emergency and evacuation procedures.
9. Infection prevention and control.
10. All Acts, regulations, policies of the Ministry and similar documents, including policies of the licensee that were relevant to the person's responsibilities.
11. Any other areas provided for in the regulations.

a) During a complaint inspection regarding staffing, the complainant told the LTCH Inspector that they had been hired through an agency to provide a specific service on a specific date in 2018. They were not a PSW and had not had any training or orientation to the home prior to attending the home for their first shift nor had they any training related to the management of a resident with responsive behaviours.

The LTCH Inspector interviewed the DOC who told them that they had used several agency staff over a period of time. There were six different agency staff that were hired by the home to provide a specific service during the review period.

The DOC told the LTCH Inspector there was no process in place to provide training or orientation to agency staff prior to the first shift at the home. When the agency personnel attended the home the first time, either the manager from the agency or a staff member of the home oriented the agency staff to the home area and the resident. There was no further training or orientation provided to the agency staff members who provided direct care to residents.

During an interview with the manager from the agency who had employed the complainant, they told the LTCH Inspector they provided no home specific training to their employees prior to them being assigned to Fairview Mennonite Home. They did review the work required to be done but did not review any of the policies of the home or other pertinent, required training.

The DOC acknowledged the home did not provide orientation and training to

agency staff members prior to their first work in the home.

b) The LTCH Inspector reviewed both annual and orientation training related to abuse for direct care staff with the DOC. The LTCH inspector could not find where it indicated the duty to make mandatory reports under section 24.

The DOC acknowledged that the annual and orientation training did not indicate the duty to make mandatory reporting under section 24.

The licensee failed to ensure that all staff at the home received their required training prior to performing their responsibilities. [s. 76. (2) 4.]

2. The licensee failed to ensure that all staff who provided direct care to residents received training in how to minimize the restraining of residents and, where restraining was necessary, how to do so in accordance with the Act and the regulations.

The LTCH Inspector reviewed the home's required training for staff who apply a restraint or monitor residents restrained by a physical device for the calendar year 2017.

Fourteen percent of registered staff and 13% of PSWs were not provided the required training in the application, use and potential dangers of these physical devices during 2017.

The DOC acknowledged that not all required staff received training related to the use of physical restraints and the minimizing of restraints in 2017. [s. 76. (7) 4.]

WN #24: The Licensee has failed to comply with O.Reg 79/10, s. 101. Dealing with complaints

Specifically failed to comply with the following:

s. 101. (1) Every licensee shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:
1. The complaint shall be investigated and resolved where possible, and a response that complies with paragraph 3 provided within 10 business days of the receipt of the complaint, and where the complaint alleges harm or risk of harm to one or more residents, the investigation shall be commenced immediately. O. Reg. 79/10, s. 101 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that the written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home had been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint.

An email was forwarded to the MOHLTC on a specific date in 2018, with a complaint email to the home attached from a specific date in 2017, indicating that the complaint email was still not addressed. The email had a list of several concerns related to resident #001's care and/or the operation of the long-term care home.

The home's copy of the complaint email included some responses from the home for some of the points, but did not include responses for all the concerns.

The DOC confirmed that there was no response or investigation to address all the concerns in the email.

The licensee failed to ensure that the written complaint made to the licensee or a staff member concerning the care of resident #001 or operation of the home had been investigated, resolved where possible, and response provided within 10 business days of receipt of the complaint. [s. 101. (1) 1.]

WN #25: The Licensee has failed to comply with O.Reg 79/10, s. 113. Evaluation Every licensee of a long-term care home shall ensure,
(a) that an analysis of the restraining of residents by use of a physical device under section 31 of the Act or pursuant to the common law duty referred to in section 36 of the Act is undertaken on a monthly basis;
(b) that at least once in every calendar year, an evaluation is made to determine the effectiveness of the licensee's policy under section 29 of the Act, and what changes and improvements are required to minimize restraining and to ensure that any restraining that is necessary is done in accordance with the Act and this Regulation;
(c) that the results of the analysis undertaken under clause (a) are considered in the evaluation;
(d) that the changes or improvements under clause (b) are promptly implemented; and
(e) that a written record of everything provided for in clauses (a), (b) and (d) and the date of the evaluation, the names of the persons who participated in the evaluation and the date that the changes were implemented is promptly prepared. O. Reg. 79/10, s. 113.

Findings/Faits saillants :

1. The licensee failed to ensure that the results of the analysis undertaken under clause (a) were considered in the annual evaluation.

As a result of the inspection related to the use of restraints, the LTCH Inspector reviewed the homes written record of their annual review of the Minimizing Restraints program.

There were two attendees, the DOC and a care coordinator. The review occurred on March 19, 2018. The written record included a policy update to remove two side rails from the policy. There were no notes of discussion regarding the monthly analysis of the use of restraints included in the written record of the annual review.

During an interview with the DOC, they acknowledged that all required components of the annual review of the minimizing restraints program were not reviewed at the annual evaluation including the results of the monthly analysis of restraining of residents. [s. 113. (c)]

WN #26: The Licensee has failed to comply with O.Reg 79/10, s. 116. Annual evaluation

Specifically failed to comply with the following:

s. 116. (1) Every licensee of a long-term care home shall ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider and a registered dietitian who is a member of the staff of the home, meets annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system. O. Reg. 79/10, s. 116 (1).

Findings/Faits saillants :

1. The licensee failed to ensure that an interdisciplinary team, which must include the Medical Director, the Administrator, the Director of Nursing and Personal Care, the pharmacy service provider a registered dietitian who was a member of the staff of the home, met annually to evaluate the effectiveness of the medication management system in the home and to recommend any changes necessary to improve the system.

The LTCH Inspector reviewed the home's annual evaluation of their Medication Management system. The DOC provided a document entitled "Program Review – 2017, Medication Management" with a specific date in 2018.

The documented participants included all of the required personnel except the registered dietitian who was a member of the staff of the home.

The DOC acknowledged the registered dietitian was not in attendance at the annual evaluation of the medication management system held on a specific date in 2018. [s. 116. (1)]

WN #27: The Licensee has failed to comply with O.Reg 79/10, s. 124. Every licensee of a long-term care home shall ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, are obtained based on resident usage, and that no more than a three-month supply is kept in the home at any time. O. Reg. 79/10, s. 124.

Findings/Faits saillants :

1. The licensee failed to ensure that drugs obtained for use in the home, except drugs obtained for any emergency drug supply, were obtained based on resident usage, and that no more than a three months' supply was kept in the home at any time.

During the medication management system review, the LTCH Inspector reviewed the homes' medication supply of non-emergency drugs with RN #103. The home has a total of 84 residents living in the home.

The drug supplies kept within the home at the time of the inspection included large quantities of Acetaminophen 325 mg, Acetaminophen 500 mg, Milk of Magnesia, Senokot, and Dulcolax suppositories.

There were also small supplies of Acetaminophen kept in the top drawer of the four medication carts.

Registered Nurse #103 acknowledged this was more than a three month supply of stock medications for use within the home.

The home's Pharmacist Consultant reviewed the drug supplies as listed above and acknowledged the home would not be able to utilize the supply within three months. [s. 124.]

Issued on this 28th day of January, 2019 (A1)

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

Amended Public Copy/Copie modifiée du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	Amended by FARAH_ KHAN (695) - (A1)
Inspection No. / No de l'inspection :	2018_727695_0015 (A1)
Appeal/Dir# / Appel/Dir#:	
Log No. / No de registre :	027151-18 (A1)
Type of Inspection / Genre d'inspection :	Resident Quality Inspection
Report Date(s) / Date(s) du Rapport :	Jan 28, 2019(A1)
Licensee / Titulaire de permis :	Fairview Mennonite Homes 515 Langs Drive, CAMBRIDGE, ON, N3H-5E4
LTC Home / Foyer de SLD :	Fairview Mennonite Home 515 Langs Drive, CAMBRIDGE, ON, N3H-5E4
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	Steve Pawelko

To Fairview Mennonite Homes, you are hereby required to comply with the following order(s) by the date(s) set out below:

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 19. (1) Every licensee of a long-term care home shall protect residents from abuse by anyone and shall ensure that residents are not neglected by the licensee or staff. 2007, c. 8, s. 19 (1).

Order / Ordre :

The licensee must be compliant with s. 19 (1) of the LTCHA.
Specifically, the licensee must:

Ensure that resident #001, #031, and any other resident are protected from abuse by anyone.

Grounds / Motifs :

1. The licensee has failed to ensure that the residents were protected from abuse by anyone.

a) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "physical abuse" means, (a) the use of physical force by anyone other than a resident that caused physical injury or pain.

In stage one of the Resident Quality Inspection (RQI), resident #003 informed the Long-term Care Homes (LTCH) Inspector that they experienced altered skin integrity after PSW #117 treated them roughly during care.

Resident #003 stated that they told registered staff about what happened and that the same PSW had been rough with them in the past.

A record review was conducted and on a specific date in 2018, Registered Practical Nurse (RPN) #110 documented that resident #003 showed them an area of altered skin integrity and indicated that it was caused by a staff member during care.

Registered Practical Nurse (RPN) #110, acknowledged that the resident informed them they were abused by a PSW and that they informed RN #122.

The Director of Care (DOC) acknowledged that this incident was alleged abuse.

b) For the purposes of the definition of "abuse" in subsection 2 (1) of the Act, "sexual abuse" means, (b) any non-consensual touching, behaviour or remarks of a sexual nature or sexual exploitation directed towards a resident by a person other than a licensee or staff member.

Resident #022 had severe cognitive impairment.

A Critical Incident (CI) report was submitted to the Ministry of Health and Long Term Care (MOHLTC) which stated that resident #022 was allegedly sexually abused by resident #014.

A record review revealed that on a specific date in 2018, a staff member saw resident #014 exhibiting sexual behaviours towards resident #022.

After the incident, resident #022 told a staff member that they did not welcome those sexual behaviours.

Personal Support Worker #108 stated that the incident was non-consensual as resident #022 asked resident #014 to stop.

Registered Nurse (RN) #119 acknowledged that resident #022 was sexually abused by resident #014 as it was non-consensual in nature.

The licensee failed to ensure that residents #003 and #022, were protected from abuse by anyone. [s. 19. (1)]

The severity of this issue was determined to be a level 3, actual harm or risk. The scope of the issue was level 2, pattern. The home had a level 2 compliance history, one or more unrelated non-compliances in the last 36 months. (695)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 11, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (b)

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 101. (4) Every licensee shall comply with the conditions to which the licence is subject. 2007, c. 8, s. 101. (4).

Order / Ordre :

The licensee shall prepare, submit and implement a plan to ensure compliance with s. 101 (4).
The plan must include, but is not limited, to the following:

a) The licensee shall prepare, submit and implement a plan that summarizes how they will ensure that the Long-Term Care Home Service Accountability Agreement (LSSA) which directed the Health Service Provider (HSP), aka the licensee, to ensure that the Resident Assessment Instrument - Minimum Data Set (RAI MDS) Tools were used correctly to produce an accurate assessment of the HSP's residents (RAI MDS data) is complied with.

b) The plan must include, but is not limited to identifying what actions need to be taken by the licensee to ensure that accurate RAI MDS coding and assessments of the HSP's residents are conducted, that employees are following appropriate coding standards, specifically with respect to coding residents for end-stage disease with six months or less to live and bedfast.

c) Please submit the written plan for achieving compliance to Farah Khan, LTC Homes Inspector, MOHLTC, by email to farah.khan2@ontario.ca by February 4, 2019.

Grounds / Motifs :

1. The licensee failed to comply with the conditions to which the licensee was subject.

The Long-Term Care Home Service Accountability Agreement (LSSA) with the

Waterloo Wellington Local Health Integration Network (LHIN) under the Local Health Systems Integration Act, 2006, in effect from April 1, 2016 to March 31, 2019, required the licensee to comply with the applicable reporting standards and requirements in both Chapter 9 of the Ontario Healthcare Reporting standards and the RAI MDS (Resident Assessment Instrument - Minimum Data Set) Tools.
The LSSA agreement also directed the Health Service Provider (licensee) to ensure that the RAI MDS Tools were used correctly to produce an accurate assessment of the residents (RAI MDS data).

During Stage 1 of the Resident Quality Inspection (RQI) process, the LTCH Inspector noted there were several residents that fell within the assigned resident list that had been coded in the RAI MDS data as J5c=1, meaning end-stage disease with six months or less to live.

The LTCH Inspector reviewed a report indicating that 24 out of the total resident bed count of 84 were at end-stage disease with six months or less to live.

The following sample of residents coded in the RAI MDS assessment as J5c=1 were reviewed:

1) Resident #019 was observed to be mobile and accepted afternoon snack from staff.

Their clinical record was reviewed by the LTCH Inspector which identified the resident was actively involved in a restorative program for mobility and was encouraged to participate in activities four to five times per week. They did not have a diagnosis of palliative care or end-stage disease.

The RAI MDS assessment in 2018, coded the resident as end-stage disease, six months or less to live.

2) Resident #020 was observed by LTCH Inspector #695, lying in their bed wide awake and was able to answer questions appropriately.

The clinical record identified the resident was actively involved in a restorative program for mobility, they were encouraged to use their mobility device properly, and they were encouraged to attend group activities and take an active social role within

the home. They did not have a diagnosis of palliative care or end-stage disease.

The RAI MDS assessment in 2018, coded the resident as end-stage disease, six months or less to live.

3) Resident #008 was observed by LTCH Inspector #696 to be sitting and was able to manoeuvre their mobility device without any difficulty. They were able to answer all questions appropriately regarding their medical conditions.

During a review of the resident's clinical record, the LTCH Inspector identified the resident was independent with mobility, they actively participated in physiotherapy to improve their performance in activities of daily living (ADLs), they were assigned to a high functioning activities group and enjoyed the outings and special events. They did not have a diagnosis of palliative care or end-stage disease.

RAI MDS assessment dated in 2018, coded the resident as end-stage disease, six months or less to live.

The acting RAI-MDS lead told the LTCH Inspector that if the resident's Changes in Health, End-Stage Disease and Signs and Symptoms (CHESS) score was higher than three and Personal Severity Index (PSI) score was higher than eight and the resident's ADLs were total care then they coded J5c=1, end-stage disease, less than six months or less to live.

The "Guide to the RAI-MDS 2.0 Assessment Form", in Chapter 2, defines J5c as "End-stage disease; 6 months or less to live – In one's best clinical judgement, the resident with any end-stage disease had only six or fewer months to live. This judgement was to be substantiated by a well-documented disease diagnosis and deteriorating clinical course.

The LTCH Inspector reviewed residents #019, #020 and #008 with the Acting RAI MDS Lead. They told the LTCH Inspector that when coding for J5c=1, they do not review any clinical records, physician notes or identify if there was any clinical deterioration. They based the coding on the CHESS and PSI scores alone.

The Acting RAI MDS Lead acknowledged that the three residents above, were coded as J5c=1 incorrectly. They stated that the home did not currently have any residents

that were end-stage disease, six months or less to live based on the RAI MDS definition found in their RAI MDS manual.

4) Resident #005 was observed sitting in a common area on two occasions in 2018. Their most recent RAI-MDS assessment coded them as bedfast. The RAI-MDS manual defined bedfast as 22 or more hours in a bed or recliner. However, there was no indication in the written plan of care that the resident was bedfast.

Registered nurse #103 stated the resident was not considered to be bedfast.

The Acting RAI-MDS Lead indicated that residents are coded as bedfast if they were in their bed or tilt wheelchair most of the time. When questioned about this, the Acting RAI-MDS Lead acknowledged the resident was not bedfast and the coding was incorrect. [s. 101. (4)]

The severity of this issue was determined to be a level 1, minimum risk. The scope of the issue was level 3, widespread. The home had a level 2 compliance history, one or more unrelated non-compliances in the last 36 months. (640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : May 31, 2019(A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 003

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 51. (2) Every licensee of a long-term care home shall ensure that,

(a) each resident who is incontinent receives an assessment that includes identification of causal factors, patterns, type of incontinence and potential to restore function with specific interventions, and that where the condition or circumstances of the resident require, an assessment is conducted using a clinically appropriate assessment instrument that is specifically designed for assessment of incontinence;

(b) each resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented;

(c) each resident who is unable to toilet independently some or all of the time receives assistance from staff to manage and maintain continence;

(d) each resident who is incontinent and has been assessed as being potentially continent or continent some of the time receives the assistance and support from staff to become continent or continent some of the time;

(e) continence care products are not used as an alternative to providing assistance to a person to toilet;

(f) there are a range of continence care products available and accessible to residents and staff at all times, and in sufficient quantities for all required changes;

(g) residents who require continence care products have sufficient changes to remain clean, dry and comfortable; and

(h) residents are provided with a range of continence care products that,

(i) are based on their individual assessed needs,

(ii) properly fit the residents,

(iii) promote resident comfort, ease of use, dignity and good skin integrity,

(iv) promote continued independence wherever possible, and

(v) are appropriate for the time of day, and for the individual resident's type of incontinence. O. Reg. 79/10, s. 51 (2).

Order / Ordre :

The licensee must be compliant with s. 51 (2) of the O. Reg. 79/10. Specifically, the licensee must:

Ensure that residents #001, #002 and #009, and any other resident who is incontinent has an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan is implemented.

Grounds / Motifs :

1. The licensee failed to ensure that every resident who was incontinent had an individualized plan, as part of his or her plan of care, to promote and manage bowel and bladder continence based on the assessment and that the plan was implemented.

a) Resident #002 had multiple medical conditions.

During an interview with PSW #106, they told the LTCH Inspector that there was no written plan for toileting resident #002. The written plan of care did not include an individualized plan for continence care.

Registered Practical Nurse #111 stated that a voiding diary was to be completed upon admission and with a change of status which would identify the resident's individual patterns. The RPN was not sure if this had been completed for resident #002.

The clinical record for resident #002 included a partially completed voiding diary.

During an interview with RCC #124, the lead for the Continence Care and Bowel Management program, they acknowledged the voiding diary for resident #002 was incomplete and the resident did not have an individualized toileting plan to manage their continence.

b) The LTCH Inspector reviewed resident #009's clinical record which assessed the resident on a specific date in 2018, to be incontinent of bladder.

Resident #009 had multiple medical diagnosis.

During an interview with PSW #123, they told the LTCH Inspector that there was no specific schedule for resident #009's toileting needs.

Registered Practical Nurse #111 acknowledged there was no individualized toileting plan for this residents continence care needs.

The RPN stated that a voiding diary was to be completed upon admission and with a change of status which would identify the resident's individual patterns. The RPN was not sure if this had been completed.

The clinical record for resident #009 included a partially completed voiding diary. The plan of care did not include an individualized plan for continence care.

During an interview with RCC #124, the Continence Care and Bowel Management Lead, they acknowledged the voiding diary for resident #009, was incomplete and the resident did not have an individualized toileting plan to manage their continence.

c) Resident #001 had a quarterly MDS assessment completed on a specific date in 2018, and the residents' continence level was assessed. The plan of care did not include an individualized plan for continence care.

Personal Support Worker #131 informed the LTCH Inspector that they tried a toileting schedule for resident #001 and it was effective some of the time but that the resident continued to have incontinent episodes.

Registered Practical Nurse #111 acknowledged that a voiding diary was not completed for resident #001 and that it should have been in order to create an individualized plan of care to promote continence for the resident.

The licensee failed to ensure that residents #001, #002 and #009, who were incontinent had individualized plans, as part of their plans of care, to promote and manage bowel and bladder continence based on the assessment and that the plans were implemented. [s. 51. (2) (b)]

The severity of this issue was determined to be a level 2, minimum harm or potential

for actual harm. The scope of the issue was level 3, widespread. The home had a level 2 compliance history, one or more unrelated non-compliances in the last 36 months. (640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Apr 08, 2019

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 004

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee must be compliant with s. 8(1) of the O. Reg. 79/10. Specifically, the licensee must:

a) Ensure that staff providing direct care follow the contents of the home's policy "Falls Prevention Program," particularly when to initiate Head Injury Routine.

b) Ensure that their "Head Trauma" policy is followed for resident #017, #022, #025, and any other resident regarding the assessments required when Head Injury Routine is initiated. The required items are to be assessed at the required times as per the policy, including the residents vital signs and neurological signs of injury.

Grounds / Motifs :

1. The licensee has failed to comply with the following compliance order CO #001 from inspection #2017_678680_001 issued on January 31, 2018, with a compliance date of February 22, 2018.

The licensee was ordered to:
The licensee shall ensure that the home's fall prevention and head trauma policy is complied with specifically but not limited to the current procedures outlined in the

head trauma policy including:
a) a neurological assessment of resident with trauma shall include head injury routine

(HIR)
1) level of consciousness (LOC)
2) orientation
3) response to commands or painful stimuli
4) motor and sensory function in all extremities (strength of grips bilaterally)
5) pupil size and reaction
6) complete vital signs (blood pressure, pulse, respiration) frequency; at time of injury repeat in one hour then every four hours for four times then if stable every shift for 72 hours-if any indication of decline in status, physician must be notified or transfer to ER
b) PN-F or PN-FI entered into the computer
c) Family and/or next of kin shall be advised of all injuries to the head

The licensee completed part b) and c) in CO #001.
The licensee failed to ensure that part a) of CO #001 was completed.

Where the Act or this Regulation required the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee was required to ensure that the plan, policy, protocol, procedure, strategy or system was (b) complied with.

In accordance with Regulation, s.48, required the licensee to ensure that the interdisciplinary programs including falls prevention and management, were developed and implemented in the home and each program must meet the requirements as set out in section 30. Each program must have a written description of the program that included its goals and objectives and relevant policies, procedures and protocols to meet the requirements as set out in section 30. O. Reg. 79/10, s.48

a) As a result of an inspection related to a Critical Incident (CI) for a fall that occurred on a specific date in 2017, the LTCH Inspector inspected the two falls that occurred the day prior to the fall in the CI report for resident #017.

The home's policy "Falls Prevention", directed staff to initiate a head injury routine

(HIR) and assess the resident's level of consciousness and any potential injury associated with the fall.

During an interview with RN #125, they stated at the time of the incident, it was the expectation of the home as per their policy, that the head injury routine be implemented.

The LTCH Inspector reviewed the clinical record and noted that the HIR did not have all the required documentation.

The HIR documentations were reviewed with RN #125 who acknowledged that they were incomplete and not in accordance with the home's policy at the time and the expectation of the home regarding the management of head injury assessments.

b) On a specific date in 2018, resident #022 fell twice and a HIR was initiated as a result of the first fall.

The home's policy "Head Trauma", directed staff to initiate head injury routine when there was trauma to a resident's head. The assessment was to include complete vital signs and complete neurological signs to be completed at the time of the injury, in one hours' time, every two hours for four times, if stable then every shift for 72 hours.

A review of the HIR with RN #119 revealed that one HIR form was completed with both times of fall noted at the top. The document was acknowledged to be incomplete.

c) On a specific date in 2018, resident #025 fell and a HIR was initiated.

A review of the clinical record noted that the HIR was incomplete. During an interview with RN #119 they acknowledged that the HIR record was incomplete.

Registered Nurse #119 acknowledged that staff did not follow the "Head Trauma" policy for residents #017, #022 and #025 as they did not assess the resident as per the home's policy for all required timelines. [s. 8. (1) (b)]

The severity of this issue was determined to be a level 2, minimum harm or potential for actual harm. The scope of the issue was level 3, widespread. The home had a

level 4 history as they had a related non-compliance with this section of the LTCHA that included:

- Compliance Order (CO) #001 issued January 31, 2018 with a compliance due date of February 22, 2018 (2017_678680_001)
(640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Mar 04, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 005

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 54. Every licensee of a long-term care home shall ensure that steps are taken to minimize the risk of altercations and potentially harmful interactions between and among residents, including,
(a) identifying factors, based on an interdisciplinary assessment and on information provided to the licensee or staff or through observation, that could potentially trigger such altercations; and
(b) identifying and implementing interventions. O. Reg. 79/10, s. 54.

Order / Ordre :

The licensee must be compliant with s.54 of O. Reg. 79/10.
Specifically, the licensee must:

Ensure that interventions for resident #013, #014, #015, and any other resident have been identified and implemented to minimize the risk of altercations.

Grounds / Motifs :

1. The licensee has failed to ensure that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents by identifying and implementing interventions.

a) On a specific date in 2017, a CI report was submitted to the MOHLTC indicating that a physical altercation took place between residents #013 and #015 which resulted in injury to resident #015. A similar incident occurred later in 2017, where both residents again had a physical altercation.

Resident #013's clinical records indicated that the resident had a history of responsive behaviours.

Resident #013 and #015 had their rooms near each other until 2018. On two separate occasions in 2017, resident #013 had an altercation with resident #015.

A review of resident #013's progress notes identified that there were three similar incidents that took place between both residents in approximately a one month period. There was no documentation to indicate that interventions were developed and implemented after each incident to minimize the risk of altercations between the two residents.

The BSO team lead stated that it was their expectation that after any physical altercation, residents were assessed and interventions were developed and implemented to prevent recurrence. They acknowledged that after each incident, no steps were taken to minimize the risk of altercations and potentially harmful interactions between residents #013 and #015 by identifying and implementing interventions.

b) A CI report was submitted by the home to the MOHLTC stating that resident #014 and resident #015 had an altercation.

A record review revealed that resident #014 had at least three similar incidences of altercation with resident #015 in approximately a two month period. After each incident, there was no documentation to indicate that interventions were developed and implemented to minimize the risk of altercations between the two residents.

RN #119 acknowledged that no interventions were developed and put in place after each altercation that took place between the two residents.

The home has failed to ensure that that steps were taken to minimize the risk of altercations and potentially harmful interactions between residents #013 and #015, and between residents #014 and #015, by identifying and implementing interventions. [s. 54. (b)]

The severity of this issue was determined to be a level 2, minimum harm or potential for actual harm. The scope of the issue was level 2, pattern. The home had a level 2 compliance history, one or more unrelated non-compliances in the last 36 months. (696)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

This order must be complied with by /
Vous devez vous conformer à cet ordre d’ici le : Feb 25, 2019

Order # / Ordre no : 006

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 110. (2) Every licensee shall ensure that the following requirements are met where a resident is being restrained by a physical device under section 31 of the Act:

1. That staff only apply the physical device that has been ordered or approved by a physician or registered nurse in the extended class.
2. That staff apply the physical device in accordance with any instructions specified by the physician or registered nurse in the extended class.
3. That the resident is monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.
4. That the resident is released from the physical device and repositioned at least once every two hours. (This requirement does not apply when bed rails are being used if the resident is able to reposition himself or herself.)
5. That the resident is released and repositioned any other time when necessary based on the resident's condition or circumstances.
6. That the resident's condition is reassessed and the effectiveness of the restraining evaluated only by a physician, a registered nurse in the extended class attending the resident or a member of the registered nursing staff, at least every eight hours, and at any other time when necessary based on the resident's condition or circumstances. O. Reg. 79/10, s. 110 (2).

Order / Ordre :

The licensee must be compliant with s. 110. (2) of O. Reg. 79/10. Specifically, the licensee must:

a) Ensure that residents #012, #017, and #019, and any other residents who are restrained by a physical device, are monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

Grounds / Motifs :

1. The licensee failed to ensure that the resident was monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose.

a) Resident #012 had a restraint implemented on a specific date in 2016, as per the physician's order.

On two separate occasions, the LTCH Inspector observed the resident with the restraint.

The resident's plan of care directed staff to monitor the resident's restraint for safety/comfort and for correct application, every two hours. On alternate two hours, staff were directed to check for safety/comfort, release and reposition the resident which resulted in hourly checks of the resident. On several occasions where the resident was required to be checked and/or repositioned during a specific month in 2018, there was no documentation to indicate this had been completed.

The DOC stated it was an expectation that when staff completed the task of checking for safety, comfort and/or repositioning of a resident on an hourly basis, that had a restraint in place, that they document their actions in the electronic clinical record.

The DOC acknowledged that on several occasions during a specific month in 2018, staff failed to monitor the resident every hour.

b) As part of an inspection related to a CI report, the LTCH Inspector reviewed the fall described in the report and the two falls that occurred the previous day.

Minimum Data Set (MDS) assessment dated August 8, 2017, assessed the resident as having cognitive deficits and requiring assistance with activities of daily living.

The resident's plan of care indicated that on a specific date in 2017, a restraint was implemented.

The following day, the resident had the restraint in place but was found on the floor with a significant injury.

The LTCH Inspector reviewed resident #017's clinical record and was not able to locate any "Restraint Monitoring Record". There were no notes in the electronic record and the electronic monitoring record was not in place at the time of the implementation of the restraint, according to RN #125.

The written plan of care for resident #017 directed staff to release and reposition the resident every two hours.

During an interview with RN #125, they stated the "Restraint Monitoring Record" would have been kept in the restraint binder at the time but the home had since changed their practice. The RN stated all forms and consents should be part of the clinical record. The RN and the LTCH Inspector reviewed the clinical record and there were no "Restraint Monitoring Records" related to the implementation of the restraint.

The RN stated it was an expectation of the home that any resident with a restraint was to be monitored every hour and that the monitoring was to be documented.

The RN acknowledged there was no documentation of any hourly monitoring of the lap belt restraint for resident #017.

c) Resident #019 had a restraint implemented on a specific date in 2018.

The LTCH Inspector observed the resident with their restraint on.

The LTCH Inspector reviewed the resident's plan of care for a specific month in 2018 and on several occasions where the resident was required to be checked and/or repositioned there was no documentation to indicate this had been completed.

The DOC acknowledged that on several occasions during a specific month in 2018, staff failed to monitor the resident every hour.

The licensee failed to ensure that residents #012, #017, and #019, who were restrained by a physical device, were monitored while restrained at least every hour by a member of the registered nursing staff or by another member of staff as authorized by a member of the registered nursing staff for that purpose. [s. 110. (2) 3.]

The severity of this issue was determined to be a level 2, minimum harm or potential for actual harm. The scope of the issue was level 3, widespread. The home had a level 2 compliance history, one or more unrelated non-compliances in the last 36 months. (640)

This order must be complied with by /
Vous devez vous conformer à cet ordre d'ici le : Feb 18, 2019

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ministère de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Order # / Ordre no : 007

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Pursuant to / Aux termes de :

O.Reg 79/10, s. 15. (1) Every licensee of a long-term care home shall ensure that where bed rails are used,

(a) the resident is assessed and his or her bed system is evaluated in accordance with evidence-based practices and, if there are none, in accordance with prevailing practices, to minimize risk to the resident;

(b) steps are taken to prevent resident entrapment, taking into consideration all potential zones of entrapment; and

(c) other safety issues related to the use of bed rails are addressed, including height and latch reliability. O. Reg. 79/10, s. 15 (1).

Order / Ordre :

The licensee must be compliant with s. 15 (1) (b) of O. Reg. 79/10. Specifically, the licensee must:

Ensure that resident #007, #008, and any other resident where bed rails are used and the entrapment assessment fails, steps are taken immediately to minimize and prevent harm to the residents, taking into consideration all potential zones of entrapment.

Grounds / Motifs :

1. The licensee has failed to ensure that where bed rails were used, steps were taken to prevent resident entrapment, taking into consideration all potential zones of entrapment.

a) During stage one of the RQI, resident #008 was triggered for a possible bed rail accident hazard.

The LTCH Inspector observed resident #008's bed with bed rails raised. The residents bed had a gap between the mattress and the wooden frame at the head of the bed.

An entrapment report completed for resident #008's bed indicated that the resident's bed failed the entrapment assessment.

The DOC confirmed that resident #008's bed failed the entrapment assessment and that no further steps were taken to resolve the problem.

b) During stage one of the RQI, resident #007 was triggered for a possible bed rail accident hazard.

The LTCH Inspector observed resident #007's bed with two bed rails raised. The residents bed had a gap between the mattress and the wooden frame at the head of the bed.

An entrapment report completed for resident #007's bed indicated that the bed failed the entrapment assessment.

The DOC confirmed that resident #007's bed failed the entrapment inspection and that nothing was done to resolve the issue.

The licensee has failed to ensure that where bed rails were used for resident #008 and #007, steps were taken to prevent resident entrapment. [s. 15. (1) (b)]

The severity of this issue was determined to be a level 2, minimum harm or potential for actual harm. The scope of the issue was level 2, pattern. The home had a level 2 compliance history, one or more unrelated non-compliances in the last 36 months. (695)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l’inspecteur

Aux termes de l’article 153 et/ou de l’article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

This order must be complied with by / Vous devez vous conformer à cet ordre d’ici le : Feb 18, 2019

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail, commercial courier or by fax upon:

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing, when service is made by a commercial courier it is deemed to be made on the second business day after the day the courier receives the document, and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Health Services Appeal and Review Board and the Director

Attention Registrar
Health Services Appeal and Review Board
151 Bloor Street West, 9th Floor
Toronto, ON M5S 1S4

Director
c/o Appeals Coordinator
Long-Term Care Inspections Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
Toronto, ON M5S 2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS RELATIFS AUX RÉEXAMENS DE DÉCISION ET AUX APPELS

PRENEZ AVIS :

Le/la titulaire de permis a le droit de faire une demande de réexamen par le directeur de cet ordre ou de ces ordres, et de demander que le directeur suspende cet ordre ou ces ordres conformément à l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée.

La demande au directeur doit être présentée par écrit et signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au/à la titulaire de permis.

La demande écrite doit comporter ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le/la titulaire de permis souhaite que le directeur examine;
c) l'adresse du/de la titulaire de permis aux fins de signification.

La demande de réexamen présentée par écrit doit être signifiée en personne, par courrier recommandé, par messagerie commerciale ou par télécopieur, au :

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

Quand la signification est faite par courrier recommandé, elle est réputée être faite le cinquième jour qui suit le jour de l'envoi, quand la signification est faite par messagerie commerciale, elle est réputée être faite le deuxième jour ouvrable après le jour où la messagerie reçoit le document, et lorsque la signification est faite par télécopieur, elle est réputée être faite le premier jour ouvrable qui suit le jour de l'envoi de la télécopie. Si un avis écrit de la décision du directeur n'est pas signifié au/à la titulaire de permis dans les 28 jours de la réception de la demande de réexamen présentée par le/la titulaire de permis, cet ordre ou ces ordres sont réputés être confirmés par le directeur, et le/la titulaire de permis est réputé(e) avoir reçu une copie de la décision en question à l'expiration de ce délai.

Le/la titulaire de permis a le droit d'interjeter appel devant la Commission d'appel et de révision des services de santé (CARSS) de la décision du directeur relative à une demande de réexamen d'un ordre ou des ordres d'un inspecteur ou d'une inspectrice conformément à l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée. La CARSS est un tribunal autonome qui n'a pas de lien avec le ministère. Elle est créée par la loi pour examiner les questions relatives aux services de santé. Si le/la titulaire décide de faire une demande d'audience, il ou elle doit, dans les 28 jours de la signification de l'avis de la décision du directeur, donner par écrit un avis d'appel à la fois à :

la Commission d'appel et de révision des services de santé et au directeur

À l'attention du/de la registrateur(e)
Commission d'appel et de revision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto ON M5S 1S4

Directeur
a/s du coordonnateur/de la coordonnatrice en matière d'appels
Direction de l'inspection des foyers de soins de longue durée
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Toronto ON M5S 2B1
Télécopieur : 416-327-7603

À la réception de votre avis d'appel, la CARSS en accusera réception et fournira des instructions relatives au processus d'appel. Le/la titulaire de permis peut en savoir davantage sur la CARSS sur le site Web www.hsarb.on.ca.

Issued on this 28th day of January, 2019 (A1)

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : Amended by FARAH_ KHAN (695) - (A1)

Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Order(s) of the Inspector

Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007*, S.O. 2007, c. 8

Ordre(s) de l'inspecteur

Aux termes de l'article 153 et/ou de l'article 154 de la *Loi de 2007 sur les foyers de soins de longue durée*, L. O. 2007, chap. 8

Service Area Office / Bureau régional de services : Central West Service Area Office